

UTILIZATION REVIEW CHECKLIST

REGIONAL OFFICE: _____ **DATE OF REVIEW:** _____

Individual Name: _____ Case #: _____

UR TOTAL \$ _____ 1ST year _____ Annual _____ Last year URL \$ _____

Additional Information: _____

PLANNING

- _____ Does the plan document the need for each service/support?
- _____ Are clear outcomes identified for each service/support?
- _____ What alternative solutions including technological, adaptive equipment, community resources have been explored to achieve identified outcomes?
- _____ Have needs been prioritized by the person/family?
- _____ How long has this level of support been in place?
- _____ Has progress toward the stated outcomes been documented?
- _____ If the person is Medicaid eligible, have applicable state plan services been accessed when they will meet the needs? **(For persons under age 21, this includes all OT, PT, and speech therapies, most adaptive equipment, diapers, and personal care that meet the state plan definition. For adults, this includes personal care provided through Department of Health and Senior Services.)** If not, why?
- _____ For children, are any services/supports requested the responsibility of the local school district? **(The Division cannot supplant services/supports that should be provided by local school districts. The plan should note therapies the child is receiving at school, including frequency, intensity, and duration.)**
- _____ For children, if additional therapies are educationally necessary, have they been pursued through the IEP process?

FINANCIAL Where applicable:

- _____ Are prescriptions or recommendations for therapies, equipment, etc., attached?
- _____ Are denial letters from insurance companies or other primary funding sources attached?
- _____ Are bids attached?
- _____ Is the budget page completed, including frequency and rates? Is the math correct?
- _____ Were there services last year which were authorized and not invoiced? If not, why?
- _____ Did last year's authorizations/expenditures match the approved budget?
- _____ Are cost projections reasonable based on ongoing service needs?
- _____ Is the proposed solution the most cost effective, if not why?

_____	Is the DD funding source noted? (i.e. Choices)
_____	Are all expenditures within the program/service cap? (ABA \$5,000; Environmental Accessibility Adaptations Home Modifications \$5,000; Choices \$3,600, etc.)
_____	Are there contracts with providers who are receiving over \$3000 per year?
_____	If there is a request for adaptive equipment (for example), does the plan identify the specific equipment/supplies needed, and the justification for each? (It is not acceptable to approve "up to" the cap for a program service without justification.)
_____	Is there a redirection of funds involved? (Do health and safety needs justify redirection?)
_____	Has the person applied for Medicaid? If ineligible, why?_____

MISSOURI VALUES

_____	Is the service a NEED rather than a WANT? To determine the difference, as the question "What would happen without the service?" 'Needs' meet health, safety, and independence requirements (as appropriate to the individual) that cannot be met by any alternative funding or program source. (Is this for maintenance of independent living, prevention from moving to a more restrictive setting, proactive prevention of a potentially abusive situation, etc.?)
_____	Does the service facilitate a typical lifestyle and not foster dependence on the system?
_____	Is the amount of support based on the level of need?
_____	Have natural supports or other ways to meet the need been explored first?
_____	Is the service/support something that families do not typically provide?
_____	Would Missouri taxpayers agree service/support should be purchased with state tax dollars?

RESIDENTIAL

_____	Is this a single person ISL? ____Yes ____No If Yes, is the following information in the plan? Other options tried? ____Yes ____No Outcomes of those options: If No, explain why
_____	Is the Administration fee limited to 15% or \$800 maximum?
_____	Are room and board costs within the financial means of the individuals living in the home?
_____	Is the level of overnight support justified in the plan?
_____	Are the hours of paid support (for example, ISL, Day Hab, Employment) limited to 24 hours per day?
_____	Are there other issues of concern?

Support Coordinator

Date

Utilization Review Committee Representative

Date